Trauma Informed Care: Principles and Case Examples

Working with Trauma Victims with Intellectual and Developmental Disabilities

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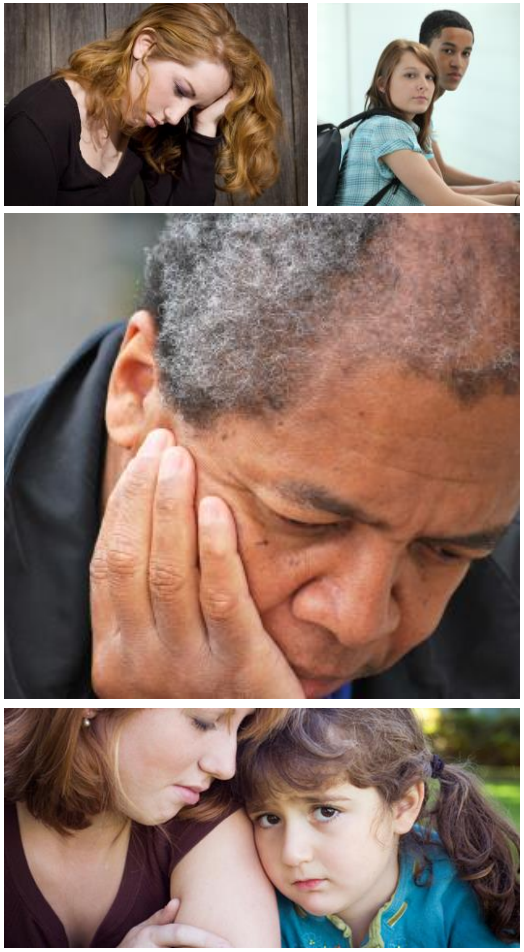

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YOUR PRESENTER

Welcome !!!!

Today we will discuss trauma, how it effects both ourselves and those we serve.

With a goal of becoming "even better" in our interactions and support, we must recognize that self-care and self-awareness are essential.

Today is not only to learn but teach, to receive and to give, and to be open to new ideas for healing and trauma-reduction. What is YOUR intention for today?

1. Trauma Informed Care

1. Trauma Informed Care

Traditional Paradigm	Trauma Informed Paradigm
➢ Clients are sick, ill or bad	➢ Clients are hurt and suffering
➢ Client behaviors are immoral and need to be punished	➢ Client behaviors are survival skills developed to live through the trauma but are maladaptive in normal society
➢ Clients can change and stop immoral destructive behavior if they only had the motivation	➢ Clients need support, trust and safety to decrease maladaptive behaviors
➢ Manage or eliminate client behaviors	➢ Provide opportunities for clients to heal from their trauma
➢ Staff should come to work every day at their best and perform to leadership's expectations	➢ Leaders need to create strong organizational culture to combat trauma and stress associated with work with traumatized clients
➢ System of care should be created to minimize short term costs and contain immoral behaviors	➢ System of care invests in healing trauma, saving money over the long term

1. Trauma Informed Care

Common/Traditional View	Trauma-Informed View
Students choose behavior and need consequences	Students want to do well but lack the skills or have learned bad behavior patterns
Characterizes student behavior negatively (i.e. manipulative)	Characterizes student behavior constructively (i.e. needs calming strategies)
Uses labels to describe students ("EBD")	Reframes behavior to identify strengths
Authoritarian	Collaborative
Minimizes coping strategies	Behavior is communication and serves a function
Academics focused	Whole-student focused
Student should already know the expectations	Teaches and re-teaches expectations using differentiation
Creates systems that make students work for support	All students receive support regardless of their needs
Staff-centered environment	Student-centered environment
Uses jargon with parents and non-educators	Uses language so that all can understand

1. Trauma Informed Care

Is often thought to be needed after a trauma has occurred.

However, it is best if it occurs at all times.

Trauma informed principles and practices are recommended in all interactions

Trauma Informed Care

Trauma Informed care is a model of thinking *and* action

Based in an awareness of the many small and large, and smaller impact and larger impact traumas ourselves & others have experienced...

And how these have effected thinking, perception, emotions, physical and mental well-being, social interaction and beliefs.

What is Trauma Informed Care?

Trauma results from event(s) that cause intense fear and suffering. These often lead to ongoing psychological and physical symptoms.

Reminders of the trauma stimulate memories (sometimes re-experiencing known as flashbacks). These reminders are called triggers, as they trigger the recollection of the event(s).

What is Trauma Informed Care?

Trauma-Informed Care is the care that is provided with an acute awareness of the survivor's traumatic experiences. Care is taken to honor the survivor's experience and its effects.

When moods, verbalizations, and conduct occurs that seems to reflect the effect of trauma on a survivor, TIC caregivers are trained to reflect upon this as a function of the trauma. All is perceived through the lens of trauma, understanding of trauma and it's variation of expression.

What is Trauma Informed Care?

Trauma-Informed Care includes familiarity with the impact of trauma on the survivor. Signs include:

Hypervigilance
Numbing
Heightened/dulled emotions
Anxiety
Depression
Suicidality

Hopelessness
Helplessness
Anger/rage
Mood changes
Isolation
Sadness

How Thinking and Attribution Change with Trauma-Informed Care

SURVIVOR DOES	ATTRIBUTION BY NON-TIC	TIC ATTRIBUTION
Gets mad “easily” (also a judgment).	Always wants his/her own way.	Understanding that fear underlies anger. Asks what is scaring the survivor.
Does not want to change clothes for bedtime.	Refuses to follow the rules. Challenges caregivers.	Survivor fears for her/his safety. Feels best (safer) with street clothes on.
Now has boundary issues, and wants too much physical touching & hugs.	Acts like a baby, is manipulating, doesn’t know limits for affection.	Needs reassurance including healing touch and closeness.
Acts uninterested, does not pay attention or is disobedient & defiant.	Has become obstinate and likes to challenge authority.	Seeks safety in isolation, often feels overwhelmed and keeps to self.
Is disobedient, always breaking the rules.	Always seeking attention. Likes to challenge the rules.	Seeks support and help. Rules sabotage healing.

TIC Principles

Embraces understanding of the role trauma plays in life of survivors/clients served.

Knowledgeable about the effects of trauma upon survivors both short- and long-term.

Familiar with concept of triggers, learns each client's triggers

Embraces philosophies of "do no harm," kindness in interactions & R-E-S-P-E-C-T.

TIC Principles

Uses healing modalities to actually improve safety and feeling of safety. (no pretending one is safe while in custody, for example)

Enhances choice, options, expression of feelings, empathy, consideration, honesty.

Allows carer, when in doubt to say, "I don't know, and I will find out."

Good supervision invites reflection, consideration of alternative perspectives, imagined "do-overs" and no-fault explorations.

TIC Recommendations
Do's and Don'ts

Do	
Invite conversation	Allow silence
Allow expression of emotions	Stay with survivor in their pain
Ask "What can I do for you now & later	Say "I don't know" (answering, "why did this happen to me" etc.)
Ask what has brought comfort in the past and if this can be accessed now.	Reflect and clarify to be sure you understand
Offer options to feeling better & healing that you can cause to be available (talk to a therapist, ASAP, go for a walk, get ice cream!)	Ask, "what should I ask you?"

TIC Recommendations
Do's and **Don'ts**

Don't	
Demand eye contact	Get too close
Talk too much	Ask too many questions
Make promises you cannot keep (I'll make sure you are safe.)	Use platitudes (this will make you stronger later)
Say, "you should be over this by now," or "you have to forgive the perpetrators(s) so you can start to heal."	Touch without spoken permission
Talk about your own trauma…keep the focus on the survivor.	Ask survivor to tell you about the traumatic incident(s)

Assuring Proper Treatment for Victims of Violence with Disabilities

ADA requires accommodations for the (mental health)patient's disability

Mental health treatment for sexual assault victims with cognitive disabilities or developmental disabilities (autism, intellectual disability) requires that the specialist providing (child) abuse or sexual assault treatment also be trained and skilled in working with people with these disabilities

The treatment may require many sessions over time, shorter sessions, adaptive equipment and Certified Interpreters unless the therapist is fluent in the signing or other communication method used by the patient

The treatment will require involvement with the family (as secondary victims) and to reinforce the treatment

The team will need to collaborate with others in the community with whom the patient is or should be involved

Understanding that trauma may not express itself in the same way in people with some disabilities...this does not mean no trauma has been felt.

TRAUMA INFORMED

T - Thinking

R - Realization

A - Assessment

U - Understanding

M - Method

A – Ad-ministrations

T – Trauma Informed Care Thinking: Do's & Don'ts

DON'T:

Engage in "crazy thinking" aka what I consider poorly thought out approaches or "interventions" Let's see what you think!

1)Rx to pretend you are safe when you are not

2)Make stuff up when you don't know (all DS adults "hump" others around age 20-21; sterilization to cure sexual orientation.)

3)Refer (gang) rape victims to Sex Ed instead of Tx

T – Trauma Informed Care Thinking: Do's & Don'ts

DO

Design compassionate & dignified care approaches, philosophies & methods that are practical & realistic

1) **Acknowledge realities & move to safer environment prn.**
2) **Ask for consultation when you are stumped! Poll the audience including your client! And supervisor!**
3) **Consider what YOU would want.**

R – Trauma Informed Care

Realize & think about what has been meaningful to you following a trauma, loss.

Many people with I/DD silently suffer losses unrecognized or minimized by others: Loss of staff; change in routine; siblings move out but the sibling with a disability doesn't; pets die; death of known persons; graduation-- long term losses of friendships. Be creative in realizing the impact of these "normal changes."

Buy cards to send. Build scrap books go to the cemetery. (Tell story of Carmina's wish to visit grave and staff delay in doing so once wish was stated.)

A – Trauma Informed Care

Assessments of outward actions that are context informed. Sometimes it is not "obvious" but sometimes it is, when you are familiar with the individual's life history.

Example: Placing a plastic knife in her vagina from Wendy's, led to one intervention that did not work, then to another that did. Sometime it IS trial and error! But the trying counts. It is MUCH BETTER when staff is aware of the individual's personal hx. RX: Read the file.

U – Trauma Informed Care

Understanding that trauma pain is expressed in sadness and anger & how to tx both with TFT

Provide a ritual or a service to acknowledge changes.

Example: My Indianapolis cousin Rev. Linda's cutting the apron strings had unexpected emotional impact on all.

Co-create rituals with your clients

M – Trauma Informed Care

Method is the message.

To show and explain your approach to clients helps them make sense of their feelings and your healing effort.

For example demonstration of caring gentle acceptance (vs harsh/strict BM/ABA) where expression of self was "addressed" or identified as a problem to be “extinguished”

M – Trauma Informed Care

Method is the message.

Good job comment by Mike after compassionate listening, explanation of what we would do & why, asking for permission to proceed!

Accepting client's elective mutism and working within this "new condition" with open acknowledgement & understanding of why people usually do this, and description of planned treatment methods. Unexpected outcome due to respect and "allowing" of client's need for safety through silence.

A – Trauma Informed Care

Administration of daily doses of appreciation recognition through CONVERSATION & kind deeds daily.

Kindness stickers. (Tell story of veggie bag lady.)

Unexpected “limit” of one kind deed per driver

Carry Out Kindness was a grassroots initiative designed to inspire acts of kindness by giving out Carry Out Kindness stickers. Just another little reminder that incorporating kind acts daily is beneficial to us all.

Katherine Metz, one of the creators and a Feng Shui mento believes that the key to happiness is in kindness. She wrote to me: "I have been doing 9 acts of kindness every day for almost a year. As a result, many more opportunities arise to be kind, and I have learned we need to practice kindness. Only then does it appear spontaneously - even on the most difficult circumstances."

Their website is now closed.

http://www.carryoutkindness.com/

Overarching Principles

Only use methods you would accept for yourself. (No programmed ABA or BM) Pillsbury loving kindness.

Do your best in interpreting emotional state of others AND check it out (verify) with the person.

Know & acknowledge that everyone experiences physical and emotional pain and seeks well being.

What's the matter with you?

"What's wrong with you?"

can be answered with "I can't find my way out of the pain."

New question:

"What happened to you?"

Ask, then listen with your whole body…all your bodies: physical, emotional, mental, spiritual, etheric. Silently sending the message: I honor you, I see you, I love the essence of you.

Group exercise 2m each.

PROMOTE Well-Being at time of disclosure or discovery of abuse

1. **Remain calm**
2. **Say, “I believe you.”**
3. **Say, “I know what to do.”**
4. **Talk about your first steps.**
5. **Do them in the victim’s presence**

PROMOTE Well-Being at time of disclosure or discovery of abuse

Learn from the mistakes of others (how we know this stuff!!!)
AVOID:

1. **Showing your outrage, shock, anger, fear**
2. **Saying "we have to go confront the perpetrator and see what he says."**
3. **Say "everything is going to be OK."**
4. **Ask, "why did you go with (perp)?**
5. **Did you tell him "no?"**

PROMOTERS OF HEALING

Being believed

Being protected

Having perpetrator removed from access to the victim

INHIBITORS OF HEALING

Saying, “You always make stuff up just to get attention”

Taking the disclosure as a joke.

Making fun of the individual (lookie, he got some last night!!!)

TIC Practices

I recommend Dr. Karyn Harvey's excellent book, "Trauma-Informed Behavioral Interventions: What Works and What Doesn't"

Available on Amazon

Available from AAIDD (Am. Assoc. on I/DD)

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2. Trauma
Direct and Indirect

Child Abuse

A hidden and not acknowledged national problem until 1962 when C. Henry Kempe published his findings of X-Rays confirming prior injuries in children

Demonstrating that such injuries could not have occurred accidentally

Illuminating a "pattern of abuse".

Domestic Violence – Violence in one's home (with parents & family, group or foster home, large "facility"

Awareness that violence of any kind within a relationship is violence

Beginning of awareness that violence by loved ones is still violence

Awareness of "date-rape"

Violence by care providers against individuals with disabilites not recognized until late '90's.

Recognized Victimizations

Child abuse

Elder abuse

Domestic Violence

Rape and Sexual Assault

College campus sexual assault

Bullying

Not-yet Acknowledged Victimization

Abuse of children & adults with intellectual and developmental disabilities

Abuse of children & adults with mental illness

Sexual assault of boys and men

Sexual assault of gays, lesbians, bi and trans as well as physical assault, verbal abuse, etc.

Abuse of people with physical disabilities, facial and other physical anomolies.

What is missing from this list?

Trauma Therapy + Vicarious Trauma

Reminder: Not only is there the directly experienced trauma (upon oneself or witnessing the trauma of others), but also the impact of vicarious trauma:

Exposure (once or multiple times) to traumatic images, accounts, videos as part of one's job. Effects may accumulate. May be less than that of direct victim. Yet take a toll on the person. Paying attention to this & self-treatment for trauma is essential for those exposed to trauma in their work. If ignored can lead to depression, PTSD, inability to continue to work or work effectively. Have you seen this happen to anyone? Let it not be you.

Trauma

Reminders of trauma occur

Volitionally (engaging in remembering)

Involuntary (intrusive thoughts, other's comments)

You don't have to yell at me!

You don't have to hit me over the head with it!

Name-calling & other derogatory behavior or words

New poorly thought out mottos, for example from "No More," "Put a nail in it." Causes survivors to immediately recall their own abuse. (Join email effort telling them to recall this painful message.)

3. Prevalence of Abuse (trauma) among Children and Adults with Intellectual and Developmental Disabilities

Prevalence of Violence Against People with Disabilities

How many are there?

People with Disabilities are said to constitute approximately 20% of the population, with 10% having severe disabilities (DOL)

There are current increases in certain types of disability due to:

Violence/Intentional Injury
- Improved medical care
- Longer life spans
- Accidents

Who are People with Disabilities?

People born with disabilities

People who acquired disabilities as children

People who acquired disabilities as adults (TABs)

People who acquired disabilities as a result of domestic violence

People who acquired disabilities as a result of criminal behavior by others

People who acquired a disability by other means

Data on Prevalence of Abuse shows that

Children with Disabilities are:

3.4 times more likely to be abused than others (Sullivan, 2001)

1.7 times more likely to be abused than others (Westat, 1991)

4-10 times more likely to be abused than others (Garbarino, 1989)

There have been two federally funded research studies on children with disabilties…since 1962.

Children with disabilities are abused more than generic kids by a factor of

Girls: 1 in 4 (25%)	**Boys: 1 in 6 (17%)**
x 1.7 = 43%	x 1.7 = 28%
x 3.4 = 85%	**x 3.4 = 58%**

Numeric palindrome.

1.7 DHHS/NCCAN (Westat Inc.,1991)

3.4 Boystown Research Hospital (Sullivan & Knutson, 2000)

Data on Prevalence of Abuse shows that

Adults with Disabilities are:

Equally as likely to be abuse victims as the generic population (Nosek, 1999) BUT

The extent of the abuse is much worse for women with disabilities.

Have equal vulnerability as children with disabilities (Baladerian,, 2001 [anecdotal]) (Why would it be different, since vulnerability transcends age categories)

More…

Powers et. al. (2002) study found that of women with physical and cognitive disabilities:

67% experienced physical abuse in their lifetime

53% experienced sexual abuse in their lifetime

These are approximately twice the rates in the non-disabled population

Nosek, Young & Rintala (1995) study found of women with physical disabilities:

62% experienced some form of abuse in their lifetime

Other studies show…

Increased rates of abuse by both men and women with disabilities from 31-83%

For women with intellectual other developmental disabilities impairments rates from 40-90%

Sobsey: 4-10 times the rate for generic persons

Adults with disabilities are abused more than their generic counterparts

Annually abuse is reported among vulnerable adults, elders and children:

5 million vulnerable adults

2 million elders

1 million children

2 million + 1 million = 3 million children/elders abused compared to **5 million** adults with disabilities who are abused

From this data, we can see that **adults with disabilities are abused more than children and elders *combined!***

(Petersilia, 2000);(NCPEA, 2013); (NACC, n.d.)

Bureau of Justice Statistics
Highlights of 2012 Report

Mandated by Crime Victims with Disabilities Awareness Act (PL 105-301), 1998

This is their third report

Addresses those 12 years of age and above

Data are age-adjusted to compensate for the fact that there are more people with disabilities in the upper age range

Household telephone survey excludes institutions

Bureau of Justice Statistics
Highlights of 2012 Report

Age adjusted rate of violent crime against persons with disabilities (28 per 1000) was nearly twice the rate for Non-disabled peers. (15 per 1000).

Serious violent victimization (see above) was 16 per 1,000 persons with disabilities compared to 5 per 1,000 NTs, over 3 times the rate for non-disabled peers.

New data released 2/20/14 publishes findings that rates of abuse of those 12-15 years old are three times that of non-disabled people in same age group.

Bureau of Justice Statistics Highlights of 2012 Report

- **AGE: in 2010 pwd between 12-15 years of age had an unadjusted rate of violent victimization (61 per 1000) nearly twice that of generic people (23 per 1000).**
- **In February 2014 new report shows rates of abuse of people with disabilities to be three times that of the generic population.**

Bureau of Justice Statistics Highlights of 2012 Report

SEX: Both M/F with disabilities were victims more than generic pop.

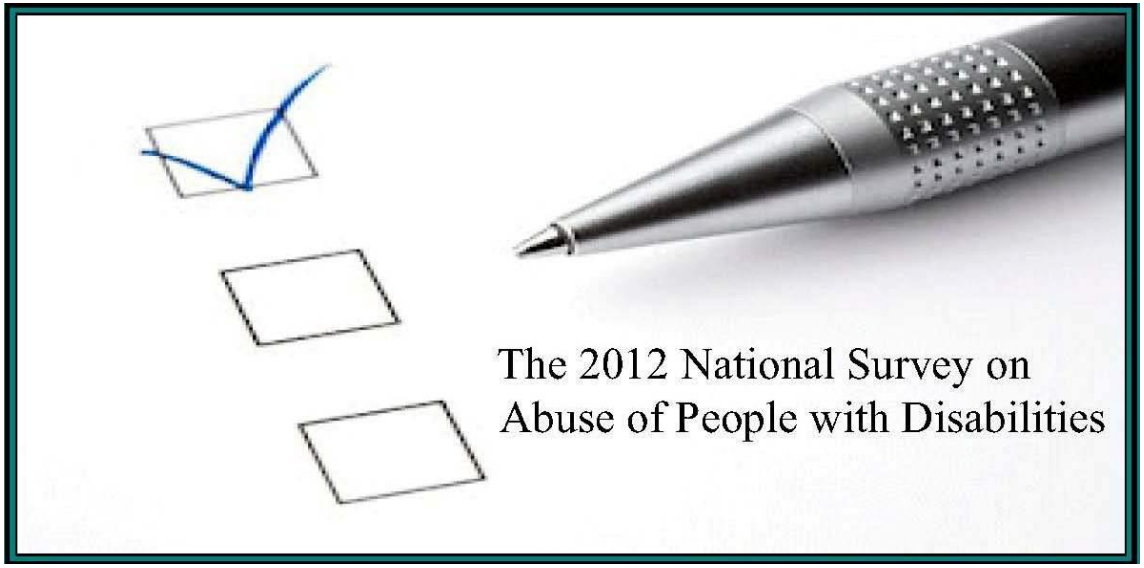
Males with disabilities: 23 per 1000

Males without disabilities: 16 per 1000

Females with disabilities: 26 per 1000

Females without disabilities: 15 per 1000

2012 National Survey on Abuse of People with Disabilities



The First Report:
Victims and Families Speak Out

Redwood Coast Regional Center Training
Eureka – October 27, 2014

Nora J. Baladerian, Ph.D.

Background on the Survey

- *The need for the survey*
- *Developing questions*
- *Distribution throughout the nation*
- *Feedback from our consultants during the analysis phase*

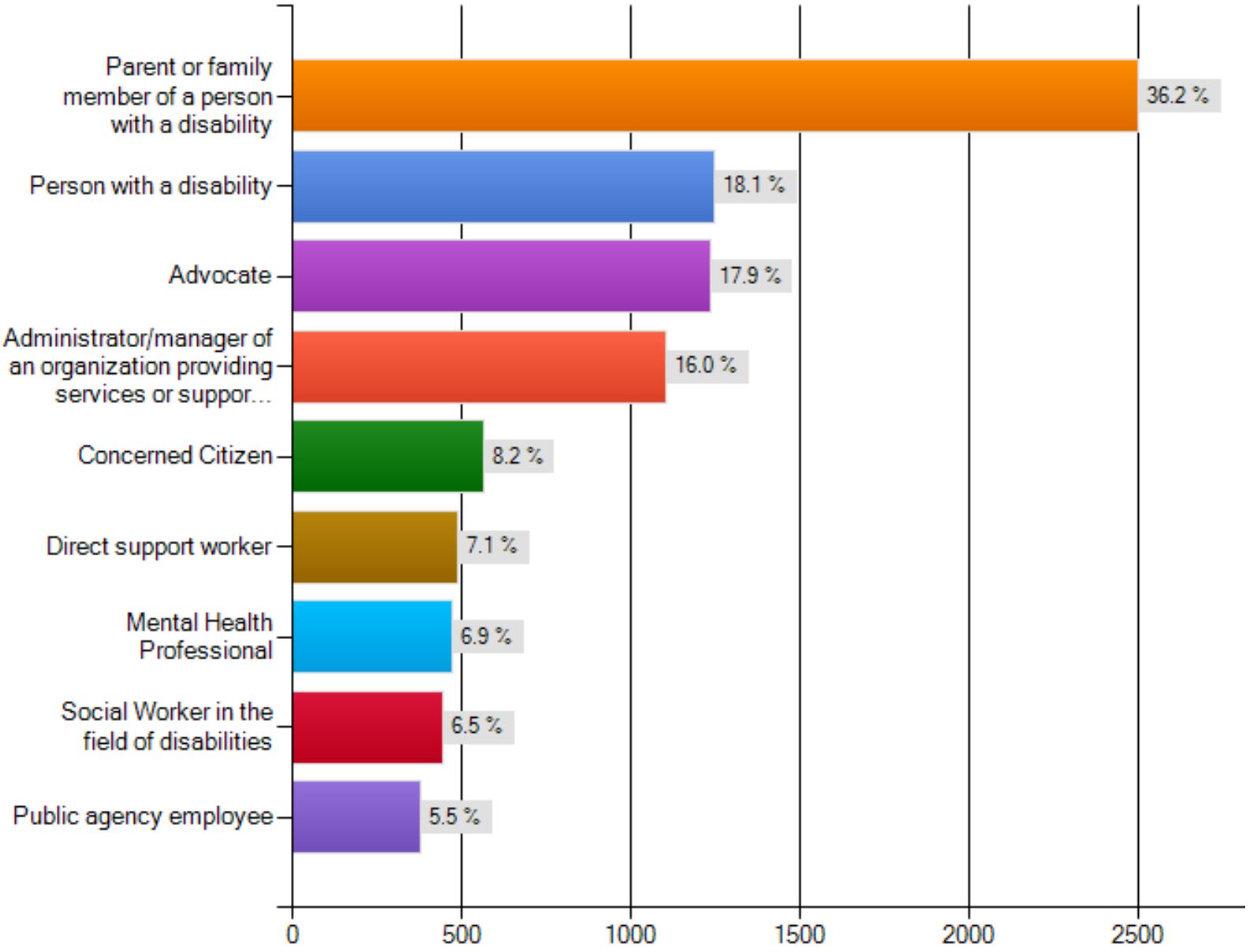
What We Knew Prior to the Survey

- *Abuse of PWD is an epidemic*
- *PWD are much more likely to be victims*
- *Cases of abuse are under-reported*
- *Victims are not getting:*
  - *equal justice*
  - *equal services*

This survey
elicited responses
from 7,289 people.

A wide variety of people took the survey.

Types of People Who Responded



This "First Report" primarily focuses on <u>2,560 responses</u> of victims and their families.

Overview of Key Findings

Abuse is prevalent and pervasive

- *Over 70% of respondents with disabilities were victims of abuse.*

- *63% of parents/family said their loved one was abused.*

It happens in many ways

- *87% emotional and verbal abuse*
- *51% physical abuse*
- *42% sexual abuse*
- *32% financial abuse*

It happens frequently

- *90% of victims suffered abuse on multiple occasions*

- *57% more than 20 times*

- *46% too many times to count*

Failure to report abuse

- ***Nearly half of victims did not report abuse to authorities.***

- ***Most thought it would be futile to do so.***

Inadequate Response

- *54% of those who did report, said nothing happened.*

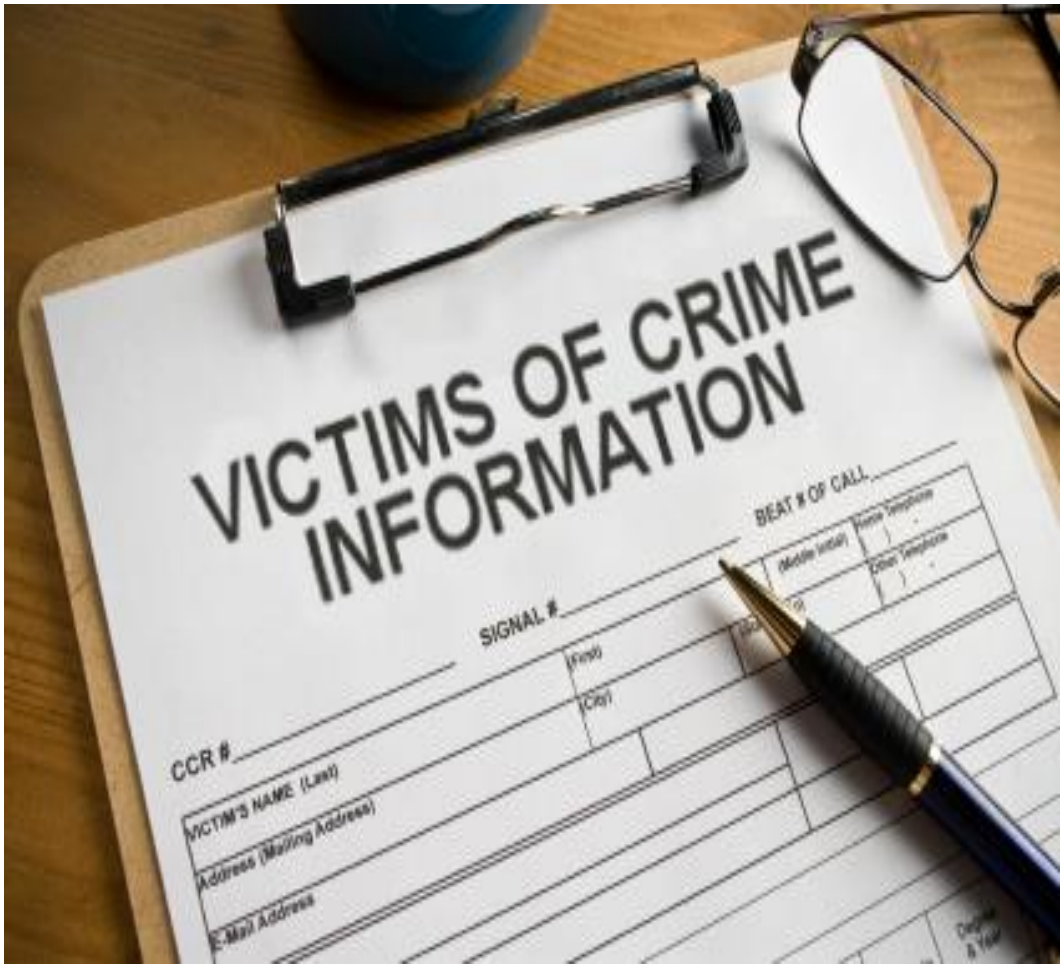
- *In fewer than 10% of reported cases were perpetrators arrested.*

83% of victims who got therapy said it was helpful.

But . . .

66% of victims were not referred to a therapist.

Fewer than 10% of victims of sexual or physical abuse received benefits from a crime victim program.



Recommendations

Reduce risk

Improve Reporting

Improve Prosecution

Improve Therapy for Victims

Improve Victim Compensation

Reduce Risk

Step 1:
Admit that abuse occurs

Step 2:
Know who likely offenders are

Step 3:
Create a risk reduction plan

Reduce Risk: Resources

Risk Reduction Workbooks:
(1)For parents and service providers
(2)For people with I/DD

The Rules of Sex: for those who have never been told

Go to:
disabilityandabuse.org/books

Improve Reporting

Parents:
Read "10 Tips" on Responding

Service Providers:
Adopt a Policy on Suspected Abuse

Disability Service Centers
Distribute brochures on abuse
Conduct seminars for parents

Improve Prosecution

First Responders and Investigators:
Need special training

Prosecutors:
Learn "best practices" of other agencies

APS/CPS
Send personnel to conferences with workshops on abuse and disability

Improve Therapy for Victims

Need more trauma therapists with skills in treating victims with disabilities

Need better referral systems by professional associations

Need better coordination between VOC programs and professional association referral systems

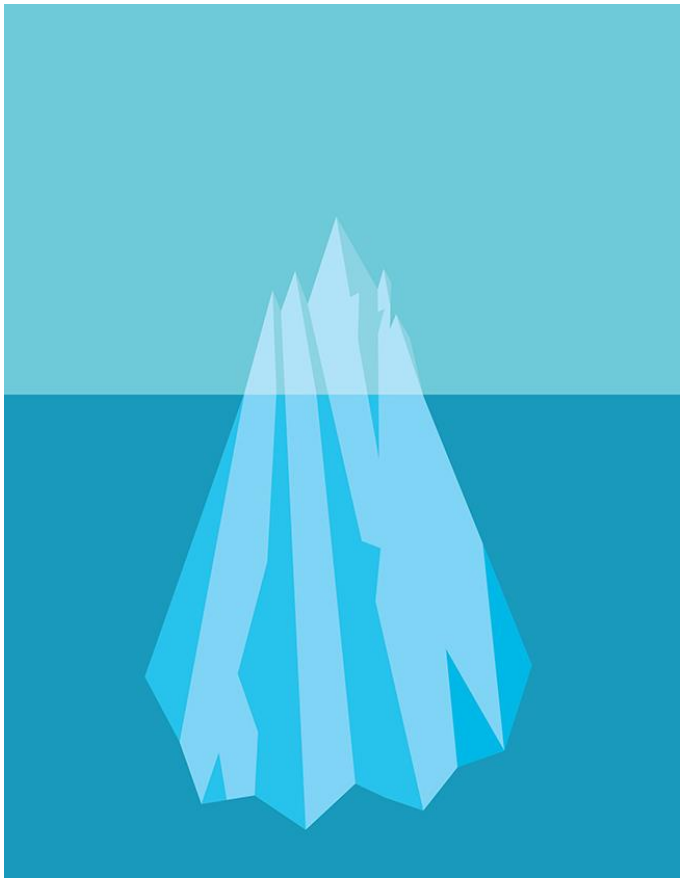
Improve Victim Compensation

Improve rate of reporting to police

Train police to refer victims to VOC programs

Service providers should tell abuse victims about the right to compensation if they report the abuse

This is
just the tip
of the iceberg



Learn More
~
Take Action

disabilityandabuse.org

4. Impact: Immediate and Long Term Effects

IMPACT & LONG TERM EFFECTS

At least the same among those with disabilities as those without disabilities.

But more complicated due to intellectual and communication disabilities, and ongoing prejudice against them due to bias against those with disabilities.

Why is this important when we are talking about adults:
Research shows that adults abused as children:

Have ongoing sequellae that impact physical, psychological and social functioning

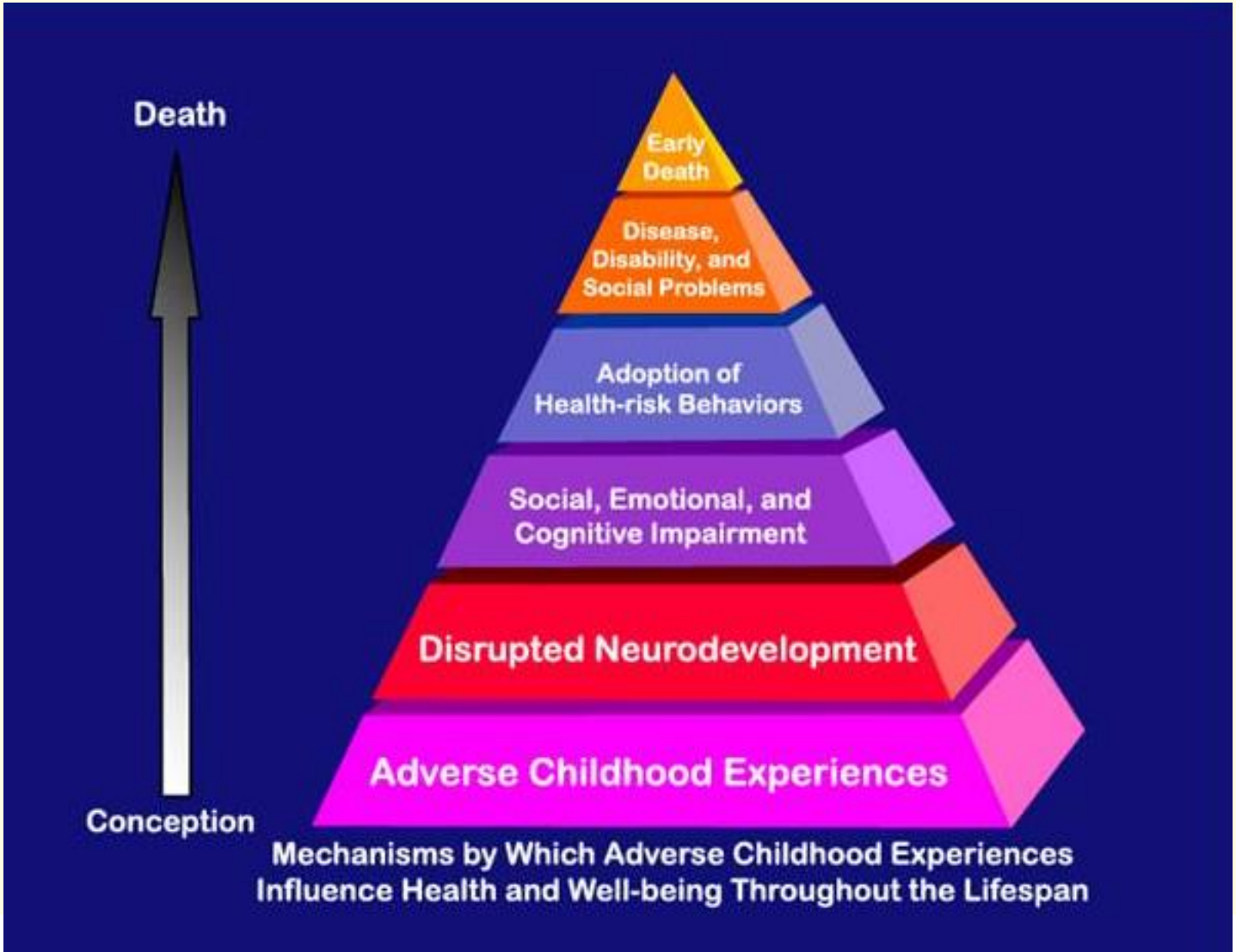
Dr. Felitti and Dr. Anda in their study at Kaiser San Diego found that >80% of those presenting for General Practice internal medicine concerns experienced childhood maltreatment.

They have demonstrated that the long term impact of childhood maltreatment is almost completely unrecognized in the health care community and involves physical maladies in adulthood.

Children with disabilities are more likely than others to become abuse victims, and

Are less likely to have resources to report and recover.

4. 4(a) Trauma's Physical Effects



ACES Prevalence (%) of Abuse and Neglect In the Original Study[1]

ACE	Women	Men	Total
	N=9367	N=7970	N=17337
Abuse			
Physical Abuse	27.0	29.9	28.3
Sexual Abuse	24.7	16.0	20.7
Emotional Abuse	13.1	7.6	10.6
Neglect			
Emotional Neglect	16.7	12.4	14.8
Physical Neglect	9.2	10.7	9.9

[1]http://www.cdc.gov/violenceprevention/acestudy/prevalence.html

ACES Prevalence (%) of Household Dysfunction In the Original Study[1]

ACE	Women	Men	Total
	N=9367	N=7970	N=17337
Household Dysfunction			
Household Substance Abuse	29.5	23.8	26.9
Parental Separation or Divorce	24.5	21.8	23.3
Household Mental Illness	23.3	14.8	19.4
Mother Treated Violently	13.7	11.5	12.7
Incarcerated Household Member	5.2	4.1	4.7

[1]http://www.cdc.gov/violenceprevention/acestudy/prevalence.html

Percent of Cumulative Adverse Childhood Experiences ACES in the Original Study[1]

Number of ACES	Women	Men	Total
	N=9367	N=7970	N=17337
0	34.5	38.0	36.1
1	24.5	27.9	26.0
2	15.5	16.4	15.9
3	10.3	8.6	9.5
4 or more	15.2	9.2	12.5

[1]http://www.cdc.gov/violenceprevention/acestudy/prevalence.html

How the ACES Work

Adverse Childhood Experiences

- Abuse and Neglect (e.g., psychological, physical, sexual)
- Household Dysfunction (e.g., domestic violence, substance abuse, mental illness)

Impact on Child Development

- Neurobiologic Effects (e.g., brain abnormalities, stress hormone dysregulation)
- Psychosocial Effects (e.g., poor attachment, poor socialization, poor self-efficacy)
- Health Risk Behaviors (e.g., smoking, obesity, substance abuse, promiscuity)

Long-Term Consequences

Disease and Disability

- Major Depression, Suicide, PTSD
- Drug and Alcohol Abuse
- Heart Disease
- Cancer
- Chronic Lung Disease
- Sexually Transmitted Diseases
- Intergenerational transmission of abuse

Social Problems

- Homelessness
- Prostitution
- Criminal Behavior
- Unemployment
- Parenting problems
- High utilization of health and social services
- Shortened Lifespan

Impact of Cumulative ACES & Social Dysfunction[1]

- Lower educational, occupational attainment.
- Increased social service costs.
- Increased medical costs.
- Shortened life span.
- Increased risk for HIV, teen pregnancy, maternal depression[2].
- Intergenerational transmission of ACES to offspring.

[1]IOM (Institute of Medicine) and NRC (National Research Council). 2013.
New Directions in child abuse and neglect research. Washington, DC: The National Academies Press.
[2]http://www.movingbeyonddepression.org/

Implications of Cumulative ACES

- "Dose-Effect" – increasing ACES increases the number of problems.
- Child maltreatment victims have 2-7 times higher risk of being re-victimized in the future compared with non-victims[1].
- Preventing future ACES in previously traumatized children is an important intervention.
- Systems that serve traumatized children – e.g., child protection, juvenile justice, mental health – should include trauma screening & prevention interventions.

[1]Finkelhor et. al (2007). Re-victimization patterns in a national longitudinal sample of children and youth. Child Abuse & Neglect 31:479-502.

Synergy

A principle finding of recent work is the extent to which two or more adverse experiences interact so that the risk of a psychological disturbance following is multiplied, often many times over.

John. Bowlby, The origins of attachment theory, 1988

Synergistic ACES Increase Complex Adult Psychopathology[1]

- People who experience one ACE are statistically likely to experience two or more ACES.
- **Synergy** is the interaction of two or more ACES so that their combined effect is greater than the sum of their individual effects.
- **Complex Adult Psychopathology** is defined as having diagnoses crossing 2 or more DSM diagnostic categories (Mood, Anxiety, Substance Abuse or Impulse Control).

[1]Putnam, Harris, Putnam, J Traumatic Stress, 26:435-442, 2013.

Addressing ACES Offers Critical Public Health Opportunities[1]

- ACES are the most preventable cause of serious mental illness.
- ACES are the most preventable causes of drug and alcohol abuse in women.
- ACES are the most preventable causes of HIV high-risk behavior (IV drugs, promiscuity).
- ACES are a significant contributor to leading causes of death (heart disease, cancer, stroke, diabetes, suicide).

[1]IOM (Institute of Medicine) and NRC (National Research Council). 2013. *New Directions in child abuse and neglect research.* Washington, DC: The National Academies Press.

Costs of Cumulative & Synergistic ACES

- Human suffering borne by victims & their families.
- Economic costs borne by society.
- Social costs borne by society.
- Intergenerational transmission of childhood adversity borne by future society.

Prevention & Treatment Costs

- Are prevention & treatment programs cost-effective?
- High quality home visiting child abuse prevention programs have been found to return ~ $3.00/dollar of cost[1].
- Evidence-based child trauma treatments such as Parent-Child Interaction Therapy (PCIT) return $3.64/dollar cost[1].

[1]Benefits and Costs of Early Intervention and Prevention Programs, Sept, 2004. http://www.wsipp.wa.gov/rptfiles/04-07-3901a.pdf.

What More Can We Do?

Adopt a Public Health approach to Child Maltreatment and other ACEs by:

1. Screening for ACEs in systems that serve children and families.
2. Building capacity to prevent & treat child trauma.
3. Increasing access to trauma-informed services for children & families.
4. Integrating and enhancing programs to target synergistic ACEs with highest cumulative risks.
5. Integrating trauma services across family-serving systems.

4(b) Trauma's Psychological Effects

Effects of Abuse

SUICIDALITY

PTSD

DEPRESSION

ANXIETY

GRIEF

NIGHTMARES

INSOMNIA

HYPERVIGILANCE

Effects of Abuse

Nightmares

Can’t sleep

Sleeps all the time

Not hungry

Will now only eat certain foods/textures

Constantly hungry

Pacing

Won’t move

Effects of Abuse

DEVELOPMENTAL REGRESSION IN

ALL ADL'S

COMMUNICATION

LEARNING

TOILETING

DRESSING

SELF-FEEDING SKILLS

ASKING FOR HELP

Effects of Abuse

CANNOT LEAVE THE HOUSE (FEARFUL)

CANNOT TOLERATE STRANGERS

CANNOT GO NEW PLACES

NEW FEARS AND PHOBIAS

CANNOT SLEEP ALONE

SEXUALIZED CONDUCT WITH SELF/ OTHERS

NEW INTEREST IN X

NO INTEREST IN PRIOR AREAS OF INTEREST

5. Suicide

Signs of Suicidality

Individual speaks of wishing to die or be dead

Desperation, desolation

Hopelessness, helplessness, ennui

ASK: If there is a plan/method, time, place, note?

ASK: What do they want/wish for

Usual signs

Self-isolation

Refuses medications and treatment

Declines participation in usual activities

Reduced hygiene, appetite, interaction

No longer: usual preferred activities

No longer talks (selective mutism)

Does not change clothes (for bedtime)

Usual signs

Mood change

Predominant mood becomes sad/mad, hopeless/helpless angry/raging, tearful/crying

Can’t stop moving (pacing, handwringing, nail biting,)

Cutting

What can you do?

Ask what do they want?

Ask what help they would like

Ask what they hope for

Ask what they want changed

Ask what you can do for them

Make sure they are physically and psychologically safe.

Immediately conduct treatment to release fears, anger, loss, that led to suicidality including hopelessness.

Options for Action

PHYSICAL:

Temporary or permanent change of residence

Temporary or permanent change of co-residents

Temporary or permanent change of staff

Increase/decrease contact with family

If increase, use telephone, Skype, Doxy.me

Review physical/emotional safety

Go to nature places (forest, lake, ocean)

Options for Action

PSYCHOLOGICAL

Immediate evaluation and treatment from a qualified mental health practitioner

No waiting list!!!!

Resist medications – all effect cognition and may dull ability to benefit from therapy

Provide time to listen to them (> time listening)

Provide information and support

Focus on hope, meaning, power, self-help

Discuss self-talk: current and changing specifics

SUPPORT

PHYSICAL SYMBOLS

Journal or workbook

Art book to express feelings

Say it is OK to yell, cry, etc.

Use energy healing methods to reduce depression, anxiety, sadness, grief, helplessness and hopelessness.

Increase presence of supervision

We are all connected

… and effect each other literally (electronically), and energetically.

Remember that!!!

(Prior to this meeting, I intended that the room be filled with great connection, communication, upliftment, inspiration and joy.)

Interpersonal Energy and its Effects

Energetic transmission

Psychological transmission

Emotional Transmission

Take hands of a neighbor,

- A: transmit any emotion.
- B: what do you feel (careful not to analyze or doubt)

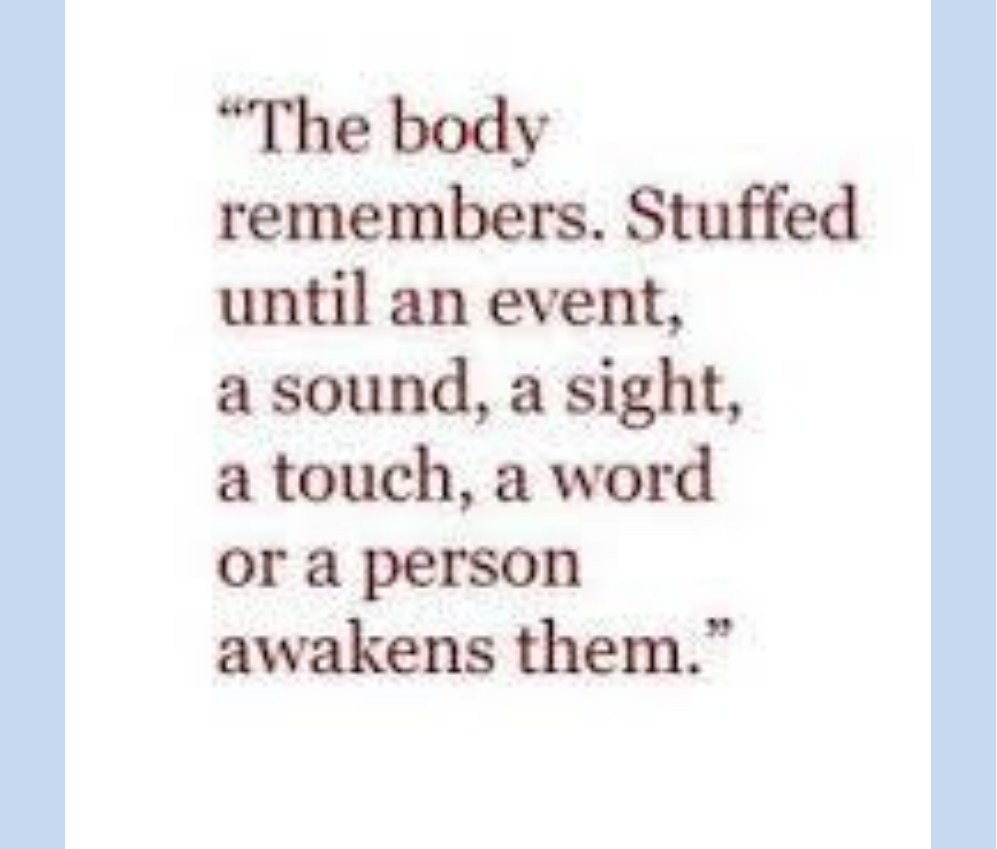
Electric transmission

Rosie

Energy Stick

6. Healing Services to Offer to Trauma Victim and Suicidal Person

No cost/low cost healing interventions anyone can do.



Now, how to heal current and historical trauma.

6. Healing Services to Offer to Trauma Victim and Suicidal Person

6. Healing Services to Offer to Trauma Victim and Suicidal Person

1. **Change practice to Trauma Informed Model or review for updating or upgrading…what's new?**
2. **Do healing work daily**
    1. Review and upgrade self-talk
    2. Do guided imagery
    3. Do mind-body practices (Levine)
    4. Do healing work (TFT) for specific mental state

6. Healing Services to Offer to Trauma Victim and Suicidal Person

Do healing work daily

5. Do appreciation rant
6. Write in journal (dictate) w/ illustrations, colors of pen
7. Engage in re-newing activities such as

   making art: painting, clay, drawing,

   making music: drumming, singing

   making dance: movement, acrobatics, waltz

6. Healing Services to Offer to Trauma Victim and Suicidal Person

Do healing work daily

8. Any activity that the individual enjoys or enjoyed in the past. Provide options.
9. Read to the person (what a pleasure that is!) Let them read to you: books, poems
10. Watch You Tubes, movies
11. Do cooking (cookies? Make designs with fruit?)
12. Think of increasing laughter and enjoyment

6. Healing Services to Offer to Trauma Victim and Suicidal Person

Do healing work daily

13. Play games: ball games, (or watch them); card games, marbles,

14. Make up stories together

15. Increase time with others

16. Do activities that match the individual's sense of meaning…what is meaningful to him/her? Give examples of what is meaningful to you.

6. Healing Services to Offer to Trauma Victim and Suicidal Person

Do healing work daily

17. Do those things that gives that person purpose. Tell them what gives you purpose in your life, to help them get started. Ask others for ideas.

18. Do those things that gives that person joy. Everyday. Tell them what gives you joy in your life, to offer ideas.

19. GROUP THERAPY PROGRAM Use existing models (mine)

6. Healing Services to Offer to Trauma Victim and Suicidal Person

Do healing work daily

20. Do Thought Field Therapy for emotional distress. This is non-invasive, effective, gives quick results that last over time, and can be learned and later taught by nearly anyone. SAMPLE:

1. Phobia (heights, dogs, public speaking, elevators, driving on a bridge, etc.

2. Want to avoid desert at lunch? How to eliminate desire for sweets.

6. Healing Services to Offer to Trauma Victim and Suicidal Person

Do healing work daily

21. Using the work of Dr. Peter Levine, who discovered an important link between animal trauma-reduction practices on the physical to the mental plane.

He studied animals who, after escaping an attack by a predator stood still for awhile, then shooooooook for awhile…then bounded off. He found this helped trauma patients over the long term who purposely shook their bodies, while focusing on their traumatic experience.

LET'S EXPERIENCE THAT RIGHT NOW!!!

8. Resources

SURVIVOR'S Workbook for Victims of Sexual Assault (Vol. I For those who read best with few words; Vol. 2 For those who read best with some words; Vol.3 For Parents and Advocates of Sexual Assault Victims with Developmental Disabilities

A Risk Reduction Workbook for Parents and Advocates of Children and Adults with Intellectual and Developmental Disabilities

8. Resources

Thought Field Therapy: "My Tapping Book" for the lay persons; "TFT for Clinicians" for mental health practitioners

"The Rules of Sex: For Those Who have Never Been Told" to help young adults know the legal & social proscriptions

Forensic interviewing skills: for responding to calls by law enforcement, paramedics, Family Services professionals, a guide to interviewing suspected crime victims with intellectual and developmental disabilities. Guidebook, DVD with training guide.

8. Resources

STAY IN TOUCH with others committed to the well-being of children and adults with I/DD by

- **Joining the CAN DO Listserv of the Disability and Abuse Project**
- **STAY UP TO DATE with a subscription to the weekly newsfeed of all articles published nationally on abuse of people with disabilities**

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Website: norabaladerian.com

REDUCE THE RISK OF ABUSE

Preventing abuse

Understanding public health concepts:

Primary – Educating everyone about a problem

Secondary – Educating those likely to have the problem

Tertiary – Providing intervention services to those who have experienced the problem

- ***Developing an "IRP", an Individualized Response Plan***

Reducing the Risk of Abuse

This is the responsibility of the systems serving individuals with disabilities, not individuals with disabilities

Yet, each individual should be encouraged to develop their own IRP, Individual Response Plan for attempted or completed assaults or other crimes. (Use Risk Reduction Planning Guides)

7. Nora's Nine Nifty Keys

COMMUNITY & AGENCY RESPONSIBILITY TO PEOPLE WITH DISABILITIES

NINE NIFTY KEYS

TO SENSITIVE SERVICE DELIVERY

TO ABUSE VICTIMS WITH DISABILITIES

Nora's Nifty Nine Keys to Effective & Sensitive Service Delivery to Survivors

1. **Nothing About Us Without Us**
2. **In all Phases and Phrases**
3. **Full ADA-guided accessibility: Spirit & Letter of the Law**
4. **All staff receive disability sensitivity training**
5. **CREDO**
6. **Recognize when you don't know & Ask when you don't know**
7. **Website Access**
8. **Monthly meetings with Disability service agencies**
9. **Utilize CAN DO & other listservs for consultation guidance & advice.**

Then START implementing your plan !!!

1. Nothing About Us Without Us

Include people with disabilities in

All planning for physical site changes

All planning for service delivery procedures, protocols and policies

Your Board membership

Your Advisory Board membership

All training activities

2. In all Phases and Phrases

All phases of service delivery planning

All phrases of whom you serve

All phrases of whom you employ

All phrases of how you serve

All depictions of whom you serve

At all sites where you deliver service (headquarters, shelters, community trainings, Board meetings)

3. Full ADA-guided accessibility: Spirit & Letter of the Law

Using your agency's requirement to be in compliance with the Americans with Disabilities Act

Both the letter and spirit of the law

Add "serving people with disabilities" into all your PSA's, brochures (for clients, public awareness and employment searches)

Assure comprehensive physical accessibility throughout your agency (and wherever you conduct business)

Assure comprehensive program accessibility throughout all services you provide

NOTE: Help is available if you are "not sure" from qualified ADA compliance support agencies and consultants.

Begin an ongoing campaign to conduct outreach activities in your area when you are ready to serve effectively.

4. All staff receive disability sensitivity training

1. **Prior to employment or within 6 weeks, *all staff* shall have completed the Disability Sensitivity & Information Training**
2. **Monthly meetings with Disability service agencies: Rotate your meetings with these agencies during the year:**
    1. CIL – Center for Independent Living
    2. Services for people who are Deaf/Hard of Hearing
    3. Services for the Blind/Visually Impaired + Deaf/Blind
    4. Services for adults with Developmental Disabilities
    5. Services for adults with mental illness
    6. Services for adults with mobility impairments (SCI)
3. **By rotating in this way, you will include most people with disabilities AND make good outreach by frequent contact.**

5. CREDO

C - Compassion

R - Respect

E - Empathy

D - Dignity

O - Open minded to needs of the survivor

- ***Demonstrated in your interactions by:***
- Time/patience
- Repetition
- Understanding that their form of communication is just as valid as yours, only different. Not better, not worse. Theirs.

6. Recognize when you don't know & Ask for help when you don't know

Be aware when you run into a situation in which you "feel" you are in unknown territory.

IT IS OK NOT TO KNOW INFORMATION AND TO NOT HAVE SKILLS YET…

It is really NOT OK to generate new "techniques" without regard to how these may effect the client…failure to interview/only interview the "other"…use self as model.

7. Website Access

Make sure your clients have access to computers at your site that are

Bobby Approved

Accessible for people with disabilities

Make sure your site is Bobby Approved!

Join listservs to stay up to date & get help

Participate in on-line learning experiences, especially the Arc-Riverside First Professional Online Conference on Abuse and Disability.

And, participate in the Arc Riverside National/International Conference on Abuse & Disability each year in March.

8. Monthly CAN DO™ meetings with Disability service agencies

Collaborative meetings with all agencies in your area that provide services to crime victims *on a regular* basis will

Ensure a better response

Educate generic service providers

Continue to make others aware of crime victims with disabilities by mentioning it at each meeting.

Conduct cross trainings between CJS/DV and disability service providers

CAN DO is a Model Program for improving response to crime victims with disabilities: These multiagency monthly meetings are modeled on the SCAN teams in child abuse. CAN DO is the Child Abuse & Neglect Disability Outreach Project.

9. Utilize CAN DO & other listservs for consultation guidance & advice.

Stay connected **with others to both give and get information & support**

Learn **about new materials as soon as they are available: videos, curricula, training programs, conferences, etc.** ***Share*** **materials you've found.**

Learn **about "tried and true" materials ("Nora ad") for stuff I've written, stuff I've collected. (Blue/brown/green/pink)**

Ask **your questions, get immediate responses from others who share your experiences.**

START

Begin work on the plan you have developed with your Board and Advisory Board.

Develop a "baseline" **from which you can measure your success and achievements.**

Develop a time line. **Reward yourself for all steps no matter how large or small.**

If you don't start now, you won't. START THURSDAY

"No one ever achieved success through the practice of procrastination".

OVC Video

“The Time is Now”

“Meet us Where We Are”

Available at no charge from the Office for Victims of Crime:

OVC Resource Center: 1 800 627 6872

TDD: 1 877 712 9279

www.ncjrs.org

The End!

Please stay in touch !!!

By visiting www.disabilityandabuse.org

By email: nora@disability-abuse.com

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